With support from The Commonwealth Fund (CMWF), the National Academy for State Health Policy (NASHP) is excited to announce a new learning collaborative for states developing and implementing programs to integrate primary care, behavioral health, and social services for individuals with chronic medical conditions and comorbidities—particularly vulnerable, low-income populations.

Integrating physical and behavioral health care delivery systems takes sustained effort and time. This learning collaborative is uniquely designed to foster integration by convening a dedicated group of experts specifically selected to help states confront and overcome obstacles in the path of integration in ambulatory settings. Selected states will receive 18-months of targeted technical assistance tailored to supporting the development and implementation of integration programs. Technical assistance includes a series of individual and group learning activities and ongoing access to state mentors, national experts, federal officials and NASHP staff. This learning collaborative will help create momentum to assist state officials, stakeholders, and, if applicable, other payers, reach consensus on critical programmatic decisions, including the target populations, project scope, role for community partners, new criteria for providers, payment models, and quality measurement and evaluation considerations.

Through this request for applications (RFA), we will select up to six (6) states to join the collaborative. Proposals will name a core team of four to six people, including a Medicaid official as the team leader, a representative from the state’s mental health or substance abuse treatment department, a consumer advisor, and other team members as selected by the state. We seek applications for participation from states that have firmly committed to integrating primary care, behavioral health, and social support services for low-income populations.¹ Selected states will demonstrate the capacity, including a hospitable legal and/or regulatory framework that permits integration efforts, and the infrastructure (such as launched Patient Centered Medical Homes or Accountable Care Organizations) to be successful. Selected states will also be at the integration “tipping point”: the critical juncture where a commitment has been made to

¹ For this learning collaborative, bi-directional integration is welcome and encouraged (i.e., states may proposed integration of primary care into behavioral health settings, behavioral health into primary care settings, or other creative integration options).
pursue delivery and payment reforms in order to strengthen and improve the state’s primary care and behavioral health infrastructure, but reforms have not yet been implemented.

The ultimate goal for this project is to support states in implementing delivery and payment reforms necessary to better integrate care for vulnerable individuals with behavioral health needs. For some states, this would mean launching a new initiative; for others it means bringing a pilot to scale. An 18-month timeline is likely too short for states that have not already started planning, therefore we would look to states that have made significant inroads on the planning process and are ready to pilot test and broad scale implementation. States may need to pass legislation or promulgate new regulations (e.g., amending data sharing laws)—or receive approval from CMS (e.g., waivers or state plan amendments)—to fully implement their initiatives. These processes can take significant time and may impact a state’s ability to launch a pilot. States that have legal and/or regulatory infrastructures that permit the needed flexibility for integration of medical, behavioral, and social services will be given priority during state selection so that this grant can be targeted on implementation efforts.2

A Time of Opportunity

The U.S. health care system is at a turning point.1 The Affordable Care Act (ACA) has brought new coverage to millions, as well as a wide range of payment and delivery reforms that present states with unprecedented opportunities for payer, provider, consumer, and other stakeholder collaboration to improve quality, control costs and provide whole-person, patient-centered care. The rapid and widespread adoption of accountable care and advanced primary care models among state Medicaid agencies, often in partnership with other payers, clearly shows that delivery system reform is a national priority and is at the heart of achieving the Triple Aim goals of improved health, improved patient experience and reduced costs.

These reforms have significant potential to support positive outcomes for individuals with chronic health conditions, including those with behavioral health care needs. According to the Centers for Disease Control and Prevention, nearly half of all Americans have at least one chronic illness, and chronic illnesses are responsible for more than three-quarters of healthcare spending and seven out of every 10 deaths in the United States.2 The degree of chronic illness in Medicaid populations is far greater than the rest of the American population; rates of diabetes, cardiovascular disease, respiratory disease, and mental illness are all significantly higher for non-elderly Medicaid adults compared to the uninsured.3 Higher prevalence of chronic illness leads to higher costs, particularly when a patient has multiple chronic conditions or comorbidities. One study found that each additional chronic condition that a disabled Medicaid-only beneficiary had was associated with an average increase of

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2 States interested in applying for this RFA are encouraged to contact NASHP staff if there are questions or concerns regarding the feasibility of project implementation in light of the applicant state’s legal and/or regulatory infrastructure as it pertains to integration of diverse medical, behavioral, and social services. In addition, there will be an informational webinar on December 11, 2014 at 1pm ET, where NASHP staff will be available to answer applicants’ questions.
approximately $8,400 in annual costs; there was also a “super-additive” effect to the trend, meaning that the cost increases are greater as more conditions are present (i.e., the increased cost of an eighth chronic condition is greater than the increased cost of a second). 4

While physical chronic health conditions and comorbidities are already costly, costs and poor outcomes are further exacerbated when an individual with a chronic health condition also has a mental health condition or substance use disorder. Although most primary care visits—up to 70 percent—are driven by behavioral health issues (including anxiety, panic, depression and stress), 5 most individuals with mental health conditions do not actually receive treatment. 6 The primary care system is often ill equipped to handle behavioral health concerns alone, with a number of studies showing that primary care providers often miss behavioral health conditions. 7 Most primary care providers lack formal processes or access to specialists to meet their patients’ behavioral health needs. 8 Even when diagnoses are made, two-thirds of physicians reported difficulty in referring patients to outpatient mental health providers. 9

The delivery and payment reforms that states are currently testing have developed a robust infrastructure on which to build. 10, 11 As of March 2014, nearly every state (46) and the District of Columbia have medical home planning or implementation activity underway and 30 of those states are actively making payments; 12 15 states have approved Section 2703 health home state plan amendments; 13 and 19 states are actively planning or implementing accountable care initiatives. 14 These and similar private initiatives have yielded promising results for both public and private payers, 15, 16, 17 but they also have their limitations. 18, 19 If significant advancements toward Triple Aim goals are to be made, the primary care system must advance toward goals of effective communication, coordination, and collaboration across the continuum of care involving behavioral health, social and community-based services, specialists, and other providers. 20, 21 Recognition of the need to further evolve advanced primary care models is evidenced by the ongoing adaptation of national accreditation standards 22 and the recent development of the “Joint Principles [for] Integrating Behavioral Health Care Into the Patient-Centered Medical Home,” 23 released by six national family medicine organizations.

With the development of the State Option to Provide Health Home Services to Enrollees with Chronic Conditions (Section 2703 of the ACA), Congress pushed the medical home model to the next step. The health home model recognizes the importance of delivering comprehensive, person-centered care for individuals with chronic physical and behavioral health conditions. To date, over half the country (26 states and the District of Columbia) has actively pursued the health home state option, having received either a planning grant and/or approval of one or more health home state plan amendments. Furthermore, recognizing the importance of strong primary care foundation as a basis for delivery system reform, the Centers for Medicare and Medicaid Innovation (established by the ACA) has awarded 25 State Innovation Model awards to states that are advancing primary care reform, behavioral health integration, and coordination across the care continuum—most through accountable care initiatives. 24
Early lessons from successful implementation of these reforms (including medical homes, behavioral health integration, and accountable care organizations), point to the need to target resources to ensure that the ‘right’ patients receive the ‘right’ kind of care at the ‘right’ point of care—in other words: complex patients with multiple chronic conditions and/or behavioral health needs receiving integrated and coordinated whole-person services in the setting where they are likely to seek the majority of their outpatient services, **whether that be a primary care, behavioral health, or other type of provider.** Recent research shows that patients with multiple chronic conditions and/or behavioral health needs are likely to benefit most from those systems that provide integrated, coordinated, data-driven, patient-centered primary and behavioral health care.\(^{25}\)

There is also a need to evolve current or develop new payment models and policies that recognize that caring for complex, vulnerable, and racially- and ethnically-diverse Medicaid populations requires coordination with multiple sectors outside of the walls of traditional medical care (such as social supports, housing, and transportation) to have a stronger impact on outcomes.\(^{26}\) States will need to consider how to operationalize an integrated ambulatory care system, including the development of supporting payment models and data systems, to achieve large and sustainable improvements in health outcomes.

**What’s in it for States?**

- $3,000 to fund distance and on-site expert technical assistance
- In-person site visit to your state from NASHP/CMWF staff
- Four national webinars with follow-up discussion from experts
- Additional travel support for one in-person kick-off meeting
- Small group learning collaboratives on shared topics of interest
- Ongoing access to NASHP staff

Each of the six states selected through this RFA will receive both group and individual technical assistance designed to help each state develop and implement its integration initiative. The technical assistance provided by NASHP as part of this learning collaborative will provide your state with access to national, federal, and state experts to identify tested strategies and best practices as you plan and implement your program.

**Individual Technical Assistance**

States selected will receive a package of individual technical assistance. NASHP will retain a group of faculty that will be available to support states in their program planning, development, and implementation. Each state will have access to a $3,000 allowance to hire these experts either for on-site and remote assistance. States may identify and suggest additional resource experts, provided they agree to the honorarium terms. Travel costs for expert faculty to travel on-site to provide assistance will be drawn from your state’s $3,000 allowance.

Additionally, a NASHP/CMWF team will visit each selected state to collaborate on key state needs including identifying project barriers and providing targeted state-specific
technical assistance. We anticipate these visits will be held between June and November 2015. If preferred by the state, the visit may coincide with additional on-site expert consultation from one or more of the learning collaborative experts. During the site visit, NASHP/CMWF staff will consult with state team members, key state officials, and stakeholders. The purpose of this visit is to meet key stakeholders, work together to further identify technical assistance needs, and provide technical assistance to establish and maintain forward momentum.

States will have unlimited access to NASHP staff, who will be available by telephone and e-mail. NASHP staff will provide a timely and actionable response to all inquiries, including referrals to experts when necessary. Bi-monthly “one-on-one” calls will be held with each state to discuss project progress and barriers. States will have the opportunity during these calls to identify and address emerging technical assistance needs.

**Group Technical Assistance**

Group technical assistance activities will include one in-person kick-off meeting (location TBD) and a series of national and small-group webinars. In addition to the four national webinars, state teams will be invited to invitation-only consultation sessions following each national webinar, as well as two sets of small-group “affinity” webinars for consortium states interested in specific topics. These webinars allow states to share experiences, identify areas of shared need, discuss emerging challenges, and receive expert technical assistance. The final agenda for each group learning activity will be developed collaboratively to meet priority technical assistance needs identified by participating states.

NASHP will fully fund all in-person meeting and travel costs for up to four members of each state team selected through this RFA. The travel funding is independent of the $3,000 technical assistance allowance provided to states. State teams may bring additional team members to the kick-off meeting at their own expense.

**Expected Outcomes for Learning Collaborative Members**

Over the next 18 months, learning collaborative state teams will strive to advance their behavioral health, primary care, and social services integration initiatives. The continued dedication and commitment of the state teams, combined with focused support from NASHP and the learning collaborative, will enable state initiatives to advance. While we acknowledge that state-specific goals and priorities will vary, the nine key accomplishments for participating states are:

1. **Agreement on a work plan that outlines shared team goals, including the project’s purpose and the process of implementation.** Selected states will begin collaboration on a work plan one month before the kick-off meeting that details the necessary steps within each activity to reach those goals. The state team leader will be responsible for developing and updating a work plan, with the input of other teammates as well as a multi-stakeholder workgroup or committee. The work plan will reflect necessary steps for selecting and implementing integration strategies, including identifying and planning for
payment, policy and practice changes. The work plan will specify responsibilities of the convening entity (most likely a state agency), the main committee, and the subcommittees, which will carry out much of the work. We expect that these subcommittees will be convened regularly by key stakeholders.

2. **Engagement of consumers in the work plan development and project planning.** Each state will designate one or more consumer representatives to inform their project. The consumer(s) will provide input to ensure that services are reflective of the values inherent in patient-centered care. Consumer representative(s) will actively promote patient- and family-centered care across the continuum by developing and promoting partnerships between primary care providers, patients/families, and the larger medical neighborhood.

3. **Development of a process to promote cross-system collaborations and partnerships.** Each state team will work across multiple agencies and form partnerships to address the diverse physical, behavioral, social service, and cultural needs of individuals across the spectrum of mental illness. States will be expected to form a larger workgroup or team (beyond the Learning Collaborative state team) that engages key stakeholders to support this project. This larger workgroup team will be supported in using tools, such as a logic model, to demonstrate who needs to be involved, their roles, and the process needed to achieve their desired goals.

4. **Identification of project scope, including participating payers, providers, and region(s).** Stakeholders will reach agreement on whether the project will be statewide or regional, multi-payer or single-payer, and the number and type of providers targeted by the intervention (e.g., primary care, behavioral health).

5. **Identification of a target population.** State teams will need to define the target population for their intervention, and develop a process for identifying members of that population within practices. State teams may select small group learning tracks to assist with this goal. Although states will be required to include Medicaid program participants with behavioral health conditions in the target population, they will need to determine how they will define that group and if their intervention will be targeted to all people with behavioral health conditions or a subset. By the end of the technical assistance period, the project will have identified the various means they will use to identify the target population and how to support practices in using that information. The team will also have entered the process needed to secure the resources, such as modifying existing contracts or securing new contractors.

6. **Development of a method for engaging and linking the patient’s main provider with other services in the neighborhood.** Each state will need to identify a primary method of integration and secure provider participation. These plans will be developed considering demographics, prevalent health
problems, access to health care, patients’ needs, and community assets. States will also need to identify a primary intervention to address integration with community support services, which might include implementing a community health team, establishing expectations that ensure existing interventions address behavioral health, requiring that practices hire care coordinators, community health workers, or train current staff to work with complex members of the target population, and provide specialized training to care coordinators. At the end of the 18-month period of technical assistance, we anticipate that states will be well on their way to implementing these strategies.

7. Establishment of new criteria or expectations for providers. Successful integration requires changes on the part of both medical homes and other providers. Primary care providers need to change how they deliver care, integrating new resources or interventions into their workflow such as care coordinators or behavior health specialists, for the target population. Other providers (e.g. behavioral health, community health teams (CHTs)) also need to change how they deliver care to ensure that referrals are effective and that information goes back to the medical home. We expect that by the end of the 18-month technical assistance period, each of the state projects will have consulted with providers, identified the expectations of providers, created new standards or criteria, develop substantive training to support the project plans for providers to implement those changes, and be in the process of implementing the policies and procedures that convey those expectations to providers.

8. Development of a payment model to support integration. State teams will collaborate on a payment model that will support the enhancements given to providers to implement the new project. Working with Medicaid, managed care organizations, and/or behavioral health organizations, state teams will also be supported to develop their payment model in collaboration with Medicare and commercial payers. By the end of this technical assistance period, we expect that payers will have selected a payment model and begun making any necessary policy changes needed to implement the model.

9. Development of a plan for using metrics for quality improvement and project evaluation. Although funding an independent evaluation of the project will be out of reach for many of the states, we expect that stakeholders will reach agreement of key performance measures for assessing the progress and quality of care across systems as well as a common set of core measures for evaluation of the intervention. These common measures should be selected for the dual purposes of quality improvement and evaluation and may already be in use for other projects in your state. Examples of quality metrics are available at:
The National Academy for State Health Policy

Through this learning collaborative, NASHP seeks to help states successfully integrate behavioral health, primary care, and social services. We look to build on the four previous learning collaboratives we have done, in which we provided direct technical assistance to advance the medical home model since 2008. NASHP has tracked, assisted, and accelerated state efforts to improve primary care advancing the medical home model for Medicaid, CHIP, and commercial populations. Of the 25 states that have participated in at least one consortium, 20 are actively making payments to medical homes, and 17 include multi-payer activity.

As an expert at the national, state, and local levels, NASHP continues to play a crucial role as states strengthen their health care system to care for complex Medicaid beneficiaries with multiple chronic health conditions and/or unmet behavioral health needs. Combining this expertise and past consortia experience, NASHP is in a unique position to directly assist states in planning and implementing integration initiatives.

Conditions of Participation

With the support of The Commonwealth Fund, NASHP plans to commit time and resources to each learning collaborative member. In return, we expect each state team to commit to improving their own initiative and helping us advance the field more broadly. Specifically, each state team will be expected to:

- Maintain a core team of at least four members, including at least one person who has decision-making authority for the state’s Medicaid program.
- Participate in bi-monthly “one-on-one” technical assistance calls with NASHP staff to discuss progress and barriers, as well as identify any emerging technical assistance needs.
- Respond to a detailed state survey on your state’s integration activity and technical assistance needs prior to the April kick-off meeting.
- Draft a preliminary work plan (a template will be provided by NASHP) identifying the goals and priorities in planning and implementing your state’s integration initiative.
- Revise your work plan as necessary for improving your state’s integration initiative during the 18-month technical assistance period.
• Participate in all group and individual technical assistance activities as planned, including in-person meetings, webcasts, conference calls, and consultation with experts. Core team members are expected to attend the April 2015 Kick-off meeting.
• Achieve goals stated in your work plan. NASHP will check in with each state team leader regarding progress toward these goals throughout the 18-month technical assistance period.
• Host one site visit for NASHP/CMWF staff between June and November 2015.
• Complete a survey update at the end of the 18-month technical assistance period.
• Review all collaborative reports and products, as requested.

Medicaid officials on each state’s core team will sign a participation agreement that summarizes the expectations listed above.

**Application Guidelines**

Applicant states must identify 4-6 members for a team for the overall project. Teams must include:

1. Senior Medicaid leadership;
2. Senior Department of Behavioral Health leadership;
3. Consumer leadership; and
4. Others based on the state’s area of focus.

All core team members are expected to attend the April 2015 Kick-off Meeting. Funding is available to cover the travel expenses of up to four team members. State teams may bring additional members at their own expense.

Applications will be assessed on three criteria, keeping in mind that the goal under this grant is to integrate behavioral health, primary care, and social services for low-income populations:

- **Progress in advancing integration initiatives:** Strong candidate states will have policies in place to develop key partnerships, support practice transformation, and measure progress. For each of these key strategies, strong candidate states will have begun planning and implementing integration efforts.

- **Commitment to advancing integrated care for low-income populations, specifically those with chronic conditions and co-morbidities.** Strong candidate states will be able to demonstrate their commitment to integrating care for low-income populations. Documentation could include: the existence of relevant legislation, dedicated funding, concept papers, previous projects, current pilot projects, use of relevant performance measures, or written support from stakeholders.
• **Potential impact of technical assistance**: Strong candidate states will explain how participation in this learning collaborative will improve or strengthen their initiative. In particular, states should indicate how aspects of the state’s initiative could benefit from additional input on implementation plans and processes.

We are also seeking diversity among selected states. We hope to include states from different regions, both urban and rural states, states that use different types of delivery systems, and states that are using different strategies for supporting medical homes.

If you have questions about this application process, we are hosting a webinar to provide you with the information you need. The webinar to review the RFA will be on December 11, 2014. To register for the webinar, please visit:

https://cc.readytalk.com/r/isoou51on2ct8eom

To apply for the learning collaborative please complete the following application electronically and e-mail it to Taylor Kniffin at tkniffin@nashp.org by **5 p.m. EDT, January 9, 2015**. Please answer the questions in no more than five double-spaced pages. We do not need extremely detailed answers to each question, but rather sufficient information to assess your initiative against the criteria listed above. We hope to notify each candidate state of the status of its application no later than **January 23, 2015**.

8 Roger G. Kathol, Frank deGruy, and Bruce L. Rollman, “Value-Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes.”
13 Ibid.
21 Diane R. Rittenhouse, Stephen M. Shortell, and Elliot S. Fisher, “Primary Care and Accountable Care—Two Essential Elements of Delivery System Reform.”
APPLICATION FOR TECHNICAL ASSISTANCE

Please answer the questions below in no more than five double-spaced pages. We do not need extremely detailed answers to each question, but rather sufficient information to assess your initiative against the criteria listed in the RFA instructions.

Please contact Charles Townley at ctownley@nashp.org if you have any questions about the application process. Applications should be submitted by e-mail to Taylor Kniffin (tkniffin@nashp.org) by January 9, 2015, 5 p.m. EDT.

Core team

*The team leader should be a senior Medicaid leadership with decision-making authority, the second member should be senior leadership from the Department of Mental Health, and the third should be consumer leadership. The fourth individual may be from any position relevant to the state’s area of focus. Fifth and sixth team members, also relevant to the state’s area of focus, may be added at the team’s discretion.*

**Team Leader (Medicaid)**
- Name: 
- Phone: 
- Title: 
- E-mail: 
- Agency: 
- Assistant: 
- Assistant’s e-mail:

**Team member 2 (Department of Behavioral Health)**
- Name: 
- Phone: 
- Title: 
- E-mail: 
- Agency/organization: 
- Assistant: 
- Assistant’s e-mail:

**Team member 3 (Consumer Leadership)**
- Name: 
- Phone: 
- Title: 
- E-mail: 
- Agency/organization: 
- Assistant: 
- Assistant’s e-mail:

**Team Member 4**
- Name: 
- Phone: 
- Title: 
- E-mail:

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3 Please note that the title “Department of Behavioral Health” is intended to include officials from your state’s mental health or substance abuse treatment departments.
Please Answer the Following Questions:

1. Briefly describe the work your state has completed or plans to complete behavioral health, primary care, and social services integration in your state.

   a. For states planning to expand a current initiative, please specify:
      - The target population for the current initiative
      - Geographic scope
      - The delivery system(s) through which you are working (e.g., managed care, primary care case management, accountable care organizations, etc.)
      - Launch date (anticipated or actual)
      - Number and names of participating payers (note: multi-payer initiatives are not a requirement under this initiative, but multi-payer participation will be considered during application review.)
      - Number of participating practices
      - Number of participating providers
      - Number of participating patients
      - How your state defines and recognizes medical homes

2. Describe your state’s plans for connecting patients with behavioral health needs with social support services.

3. Identify and describe your state’s specific strengths and weaknesses in meeting both the physical health and behavioral health needs of your state’s Medicaid population.

4. Describe your state’s strategies or plans to engage stakeholders in implementation efforts.

   a. Does your state have an existing integration committee or task force? If so, please describe the membership and provide information on the frequency of meetings. Would you be willing to share minutes of past and future meetings?

   b. Have you involved consumers?

5. Have payers in your state (either public or private) made efforts to align payment and purchasing policies to promote medical homes? If so, please describe, including whether payers have attempted to align policies across additional payers.
6. Have payers in your state (either public or private) supported practice transformation supports (beyond offering enhanced payment) to advance medical homes. If so, please describe, including whether there has been any integration with community or public health infrastructure to help support patients and practices?

7. Are there any notable challenges you are facing (or anticipate facing) in implementing an integration initiative?

8. Does your state plan to participate in any other relevant integration programs or demonstrations? If so, do you have plans to connect those programs with this learning collaborative? Please describe.

9. Please describe how technical assistance from the learning collaborative could help your initiative overcome any challenges described above and take advantage of new opportunities.

10. Please confirm that all core team members will participate in the April 2015 Kick-off meeting.

11. The team leader must be a representative of the Medicaid agency with decision-making authority. Please describe the responsibilities of that member of your team.